

Long Acting Reversible Contraception: LARC

Health and Well Being Workgroup
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Evolution of Contraception

- From 40 years of hormonal contraception through birth control pills and other methods that require daily memory and/or dependent upon individual activity usage
- To more effective and reliable methods that include hormonal implants and hormonal/nonhormonal uterine devices

Definition of LARCs

ACOG:

“Long-acting reversible contraceptives, intrauterine devices and implants are methods that have multiple advantages over other reversible methods. Most importantly, once in place, they do not require maintenance and their duration of action is long, ranging from 3 to 10 years.”

Types of LARCs and Mechanism of Action

- Intrauterine device or system (IUD/IUS)
 - Mirena: create thickened cervical mucus which is impermeable by sperm and also prevention of ovulation
 - Paragard: prevents pregnancy by creating a hostile environment for sperm to travel (pre-fertilization)
 - Skyla: create thickened cervical mucus which is impermeable by sperm and also prevention of ovulation
- Implantable devices
 - Nexplanon: create thickened cervical mucus which is impermeable by sperm and also prevention of ovulation

Contraceptive Effectiveness

Figure 3-1 Comparing typical effectiveness of contraceptive methods

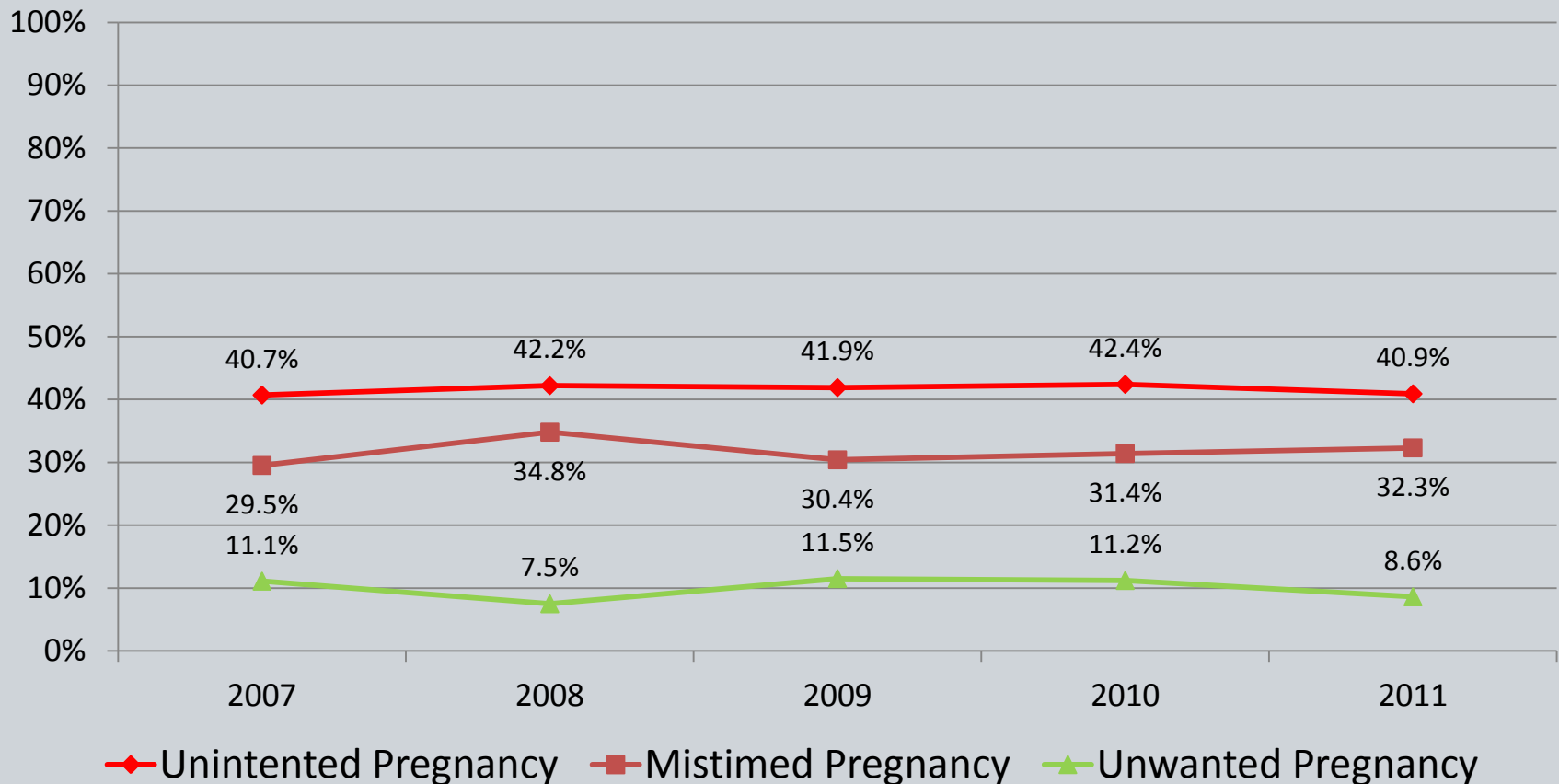


Benefits of LARCS

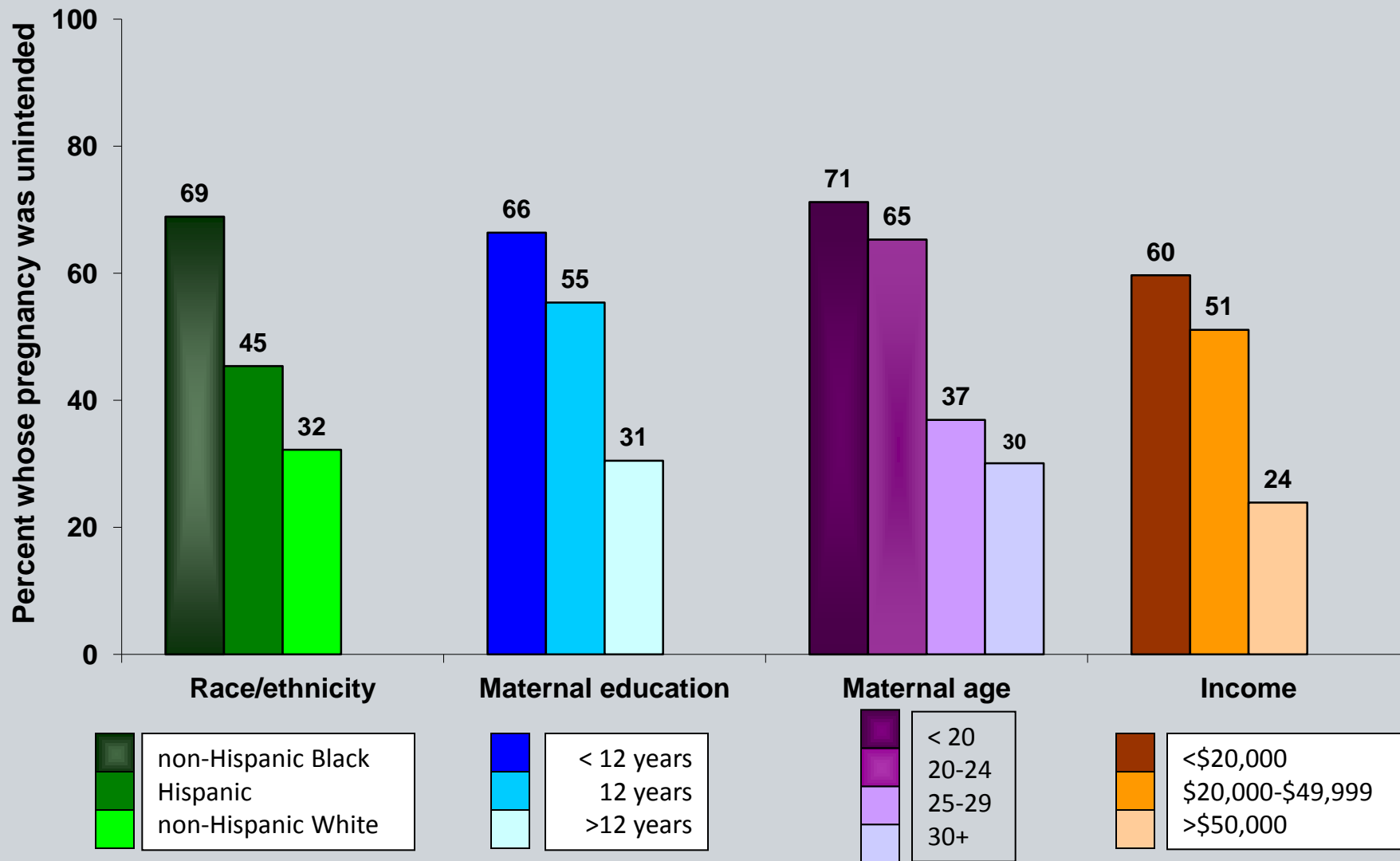
- Reduce unintended pregnancy
- Increase inter-birth interval
- Improved birth outcomes
- Increased thriving infants

Pregnancy Intention

Percent of women having a live birth who reported their most recent pregnancy was Unintended [Mistimed or Unwanted], Virginia 2007-2011



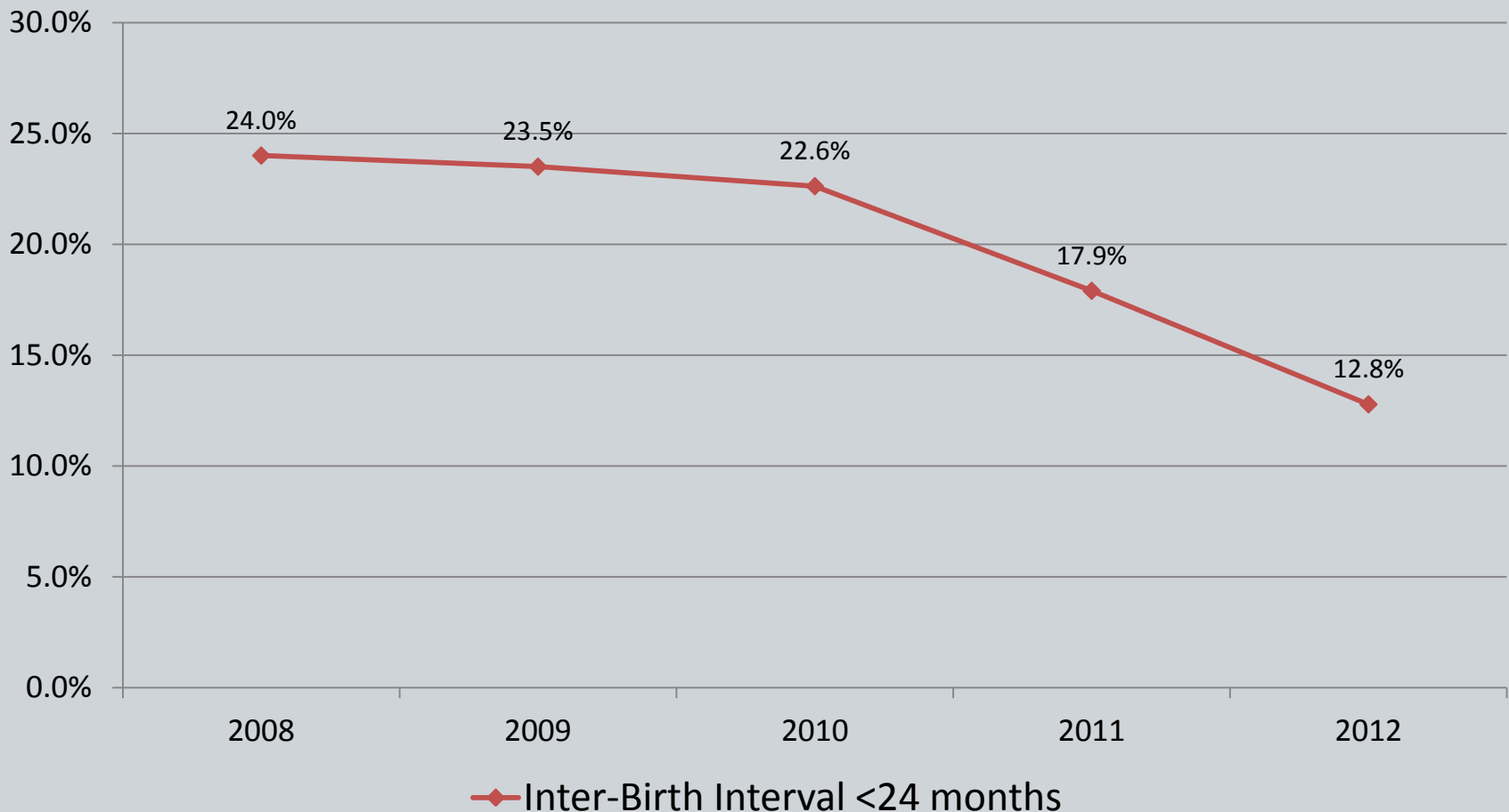
Percent of mothers who had an unintended pregnancy 2010-2011 Virginia PRAMS



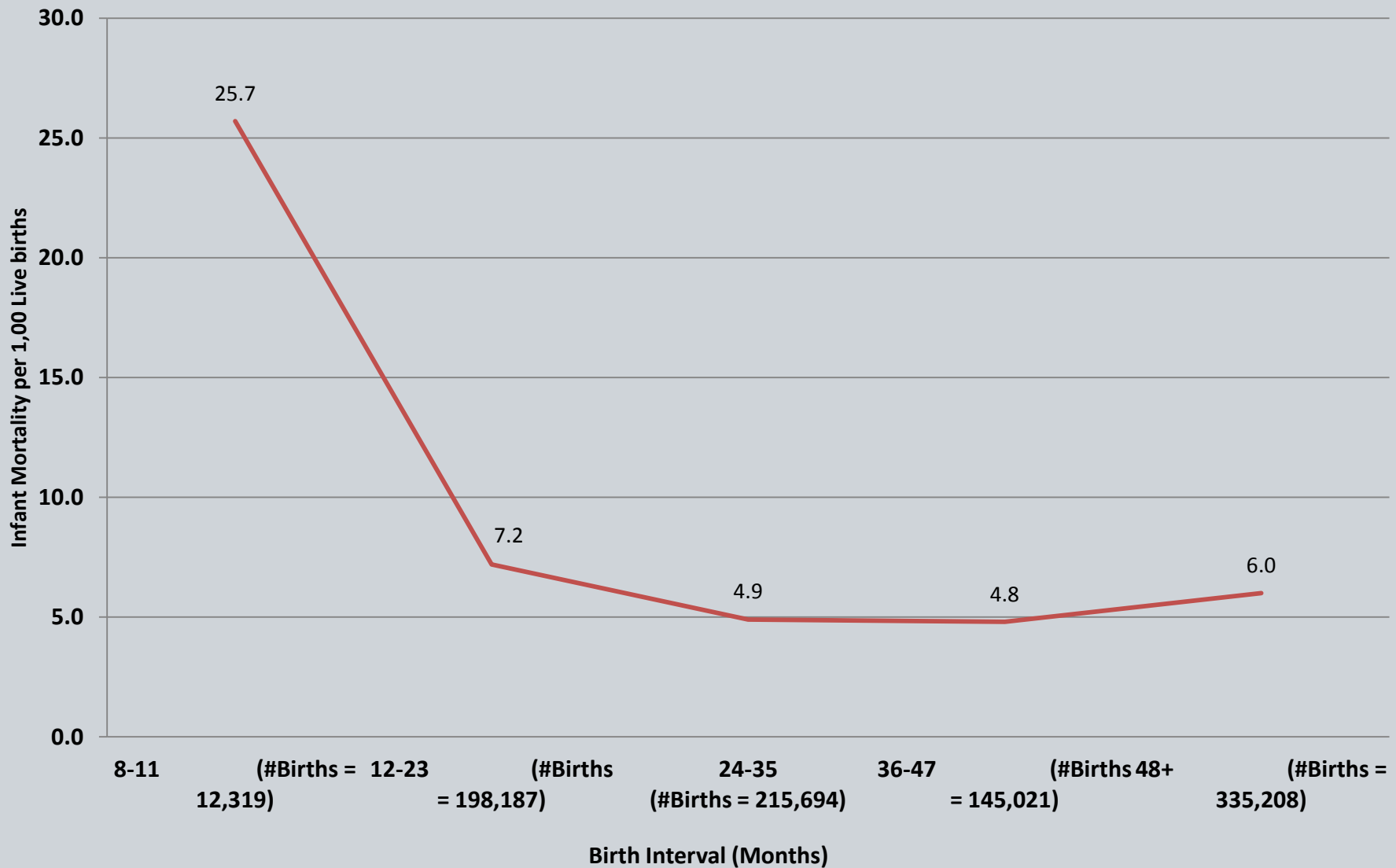
Source: Virginia Department of Health, Pregnancy Risk Assessment Monitoring System, 2010-11.

Inter-Birth Interval

Percent of women having an inter-birth Interval less than 24 months since their last live birth,
Virginia 2008-2012



Infant Mortality Rate by Preceding Birth Interval, Virginia 1993-2009



Virginia Publically funded Delivery

- As of November 2, 2014, there are 16,912 women enrolled in Medicaid FFS or FAMIS MOMS
- In 2012, nearly 30% of all live births were paid for by Medicaid and of those
 - 67% enrolled in MCO at time of delivery
 - 33% of deliveries were women enrolled in FFS
 - 14% of deliveries are covered by emergency Medicaid (covers only delivery costs)

Postpartum Visits Lost to Follow-up

- 41% of Medicaid recipients in California of eligible postpartum patients had a claim filed for contraception in the 90 days postpartum.
- Even among women seen more than once in the 90 days postpartum, 33% had no contraceptive claims.
- In trials, LTF-U occurs; 1/3 of women assigned to immediate postpartum versus 3% delayed long-acting devices

The CHOICE project in St. Louis

- Provided no-cost contraception to 9,256 women (75% of whom chose long-acting reversible methods)
- Within 4 years, the researchers demonstrated lower failure rates (<1%),
 - higher continuation
 - and satisfaction rates,
 - a decrease in unintended pregnancy
 - and abortion rates to half that of regional and national rates among users of long acting as compared to shorter acting methods.

Game Change in Colorado

- In 2009, 28 Title X funded agencies received private funding to address barriers to LARC use
 - Training providers
 - Financing LARC method provision
- By 2011, results:
 - 23% increase in caseloads
 - LARC use among 15-24 year olds increased from 5% to 19%
 - Observed fertility rates, high risk births, and abortion rates were lower across age groups

Missed opportunity

- Immediate post partum long acting reversible contraception (IPP LARC)
 - Intrauterine device or system (IUD/IUS)
 - Mirena
 - Paragard
 - Implantable devices
 - Nexplanon
- Safe
- Reversible
- Highly effective

Disparities

- Among women experiencing a repeat pregnancy in 0-23 months in 2011,
 - 64% of women were <19 years old
 - 36% of women 19-24 years old
 - Black, Non-Hispanic women
 - 42% of teens have had intercourse with the majority reporting some contraceptive use:
 - typically withdrawal
 - oral contraceptive pills
 - methods with low typical-use effectiveness.

Challenges to Immediate PP LARC

- Bundling of prenatal, delivery, and postpartum services based on diagnosis related group guidelines.
 - Under the current reimbursement guidelines, if a practitioner were to provide a LARC method following placental removal, the hospital would not be reimbursed for the device and the practitioner may not be paid for the insertion fee.
- Public Awareness of LARC benefits
- Provider awareness
- Hospital systems change

Publically Funded Reimbursement: Policy Changes

- Publically funded reimbursement
 - South Carolina
 - J-codes and family planning modifier
 - Colorado, Iowa, New Mexico, Georgia, Alabama, New York and Washington D.C.
- MCOs
 - Medicaid budget authority needed
 - MCO contract and capitation rates would need modified
- As Medicaid goes, so go other reimbursement plans?

Virginia Recommendations and Initiatives

- MCO: Current discussions and efforts including evaluation
- Virginia Thriving Infants Initiative:
 - LARC strategy action plan with a focus on health disparities
- Consider collaboration with Virginia Association of Health Plans and survey private payer reimbursement policies
- Expansion of reimbursement policy changes across all payers

Evaluation of IM PP LARC

- Data collection
 - Birth Certificates versus CPT data
 - Increase percentage of births >24 months from initial birth per mother
 - Increase # of diagnosis codes v25.11 or v25.55
 - PRAMS
 - Increase pregnancy intendedness
 - # of hospitals reporting IM PP LARC insertions

Additional resources

- ACOG's LARC Program:
[http://www.acog.org/About ACOG/ACOG Departments/Long Acting Reversible Contraception](http://www.acog.org/About_ACOG/ACOG_Departments/Long_Acting_Reversible_Contraception)

Thank you!

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